



## Complete Summary

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### GUIDELINE TITLE

Depression and mania in patients with HIV/AIDS.

### BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Depression and mania in patients with HIV/AIDS. New York (NY): New York State Department of Health; 2008 Jun. 23 p. [27 references]

### GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Depression and mania in patients with HIV/AIDS (updated online 2005 Mar). In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2001 Mar. p. 1-20.

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## SCOPE

### DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Mental disorders in HIV-infected patients:
  - Depression including depression in pregnant and postpartum women
  - Mania

### GUIDELINE CATEGORY

Diagnosis  
Evaluation  
Management  
Screening  
Treatment

## **CLINICAL SPECIALTY**

Allergy and Immunology  
Family Practice  
Infectious Diseases  
Internal Medicine  
Obstetrics and Gynecology  
Psychiatry

## **INTENDED USERS**

Advanced Practice Nurses  
Health Care Providers  
Nurses  
Physician Assistants  
Physicians  
Public Health Departments

## **GUIDELINE OBJECTIVE(S)**

To provide guidelines for diagnosis and treatment of depression and mania in patients with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) in primary care settings

## **TARGET POPULATION**

Patients with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) including pregnant and postpartum women

## **INTERVENTIONS AND PRACTICES CONSIDERED**

### **Depression (Screening, Diagnosis, Treatment)**

1. Screening for depression using one of the screening tool options
2. Use of *Diagnostic and Statistical Manual of Mental Disorders - IV (DSM-IV)* criteria
3. Paying specific attention to patients taking interferon-alpha and those with changes in body fat
4. Antidepressant medications:
  - Selective serotonin reuptake inhibitors
  - Novel antidepressants
  - Tricyclic antidepressants
  - Psychostimulants
5. Psychotherapy
6. Alternative therapies (e.g., St. John's Wort)

7. Follow-up
8. Management of depression in pregnant and postpartum women

### **Mania (Screening, Diagnosis, Treatment)**

1. Use of *DSM-IV* diagnostic criteria for mania
2. Prompt referral of patients experiencing mania for psychiatric consultation
3. Medications
4. Combination of psychotherapy with medication

### **MAJOR OUTCOMES CONSIDERED**

- Effectiveness of screening techniques in detecting unrecognized depression
- Effectiveness of interventions to treat depression

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

Not stated

### **NUMBER OF SOURCE DOCUMENTS**

Not stated

### **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Expert Consensus (Committee)

### **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

Not applicable

### **METHODS USED TO ANALYZE THE EVIDENCE**

Review

### **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not stated

### **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

AIDS Institute clinical guidelines are developed by distinguished committees of clinicians and others with extensive experience providing care to people with human immunodeficiency virus (HIV) infection. Committees\* meet regularly to assess current recommendations and to write and update guidelines in accordance with newly emerging clinical and research developments.

The Committees\* rely on evidence to the extent possible in formulating recommendations. When data from randomized clinical trials are not available, Committees rely on developing guidelines based on consensus, balancing the use of new information with sound clinical judgment that results in recommendations that are in the best interest of patients.

\*Current committees include:

- Medical Care Criteria Committee
- Committee for the Care of Children and Adolescents with HIV Infection
- Dental Standards of Care Committee
- Mental Health Committee
- Women's Health Committee
- Substance Use Committee
- Physician's Prevention Advisory Committee
- Pharmacy Committee

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

External Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

All guidelines developed by the Committee are externally peer reviewed by at least two experts in that particular area of patient care, which ensures depth and quality of the guidelines.

## **RECOMMENDATIONS**

### **MAJOR RECOMMENDATIONS**

## Depression

### Screening for Depression

Clinicians should screen for depression as part of the annual mental health assessment and whenever symptoms suggest its presence (see [Appendix I: Mental Health Screening Tools](#) in the "Availability of Companion Documents" field for screening tool options).

See the original guideline document for simple screening techniques, symptoms of depression, and behavioral changes that may be indications of an underlying depressive disorder.

HIV-infected patients do not become depressed simply because their disease progresses; however, it is particularly important to screen for depression during the crisis points noted below.

**Table: Crisis Points for HIV-Infected Persons**

- Learning of HIV-positive status
- Disclosure of HIV status to family and friends
- Introduction of medication
- Occurrence of any physical illness
- Recognition of new symptoms/progression of disease (e.g., major decrease in CD4 cells, increase in viral load)
- Necessity of hospitalization (particularly the first hospitalization)
- Death of a significant other
- Diagnosis of AIDS
- A return to a higher level of functioning (e.g., re-entry into job market/school, giving up entitlements)
- Major life changes (e.g., childbirth, pregnancy, loss of job, end of relationship, relocation)
- Necessity of making end-of-life and permanency planning decisions

### Diagnosis

Clinicians should use the diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV)* to diagnose depression (see table below).

**Table: Diagnostic Criteria For Major Depressive Episodes**

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.**

**Note:** Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made

**Table: Diagnostic Criteria For Major Depressive Episodes**

by others (e.g., appears tearful).

**Note:** In children and adolescents, this can be irritable mood.

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

**Note:** In children, consider failure to make expected weight gains.

4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

- B. **The symptoms do not meet criteria for a mixed episode.**
- C. **The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.**
- D. **The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).**
- E. **The symptoms are not better accounted for by bereavement (i.e., after the loss of a loved one), the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.**

### **Depression and Co-Existing Medical Conditions**

The primary care clinician should work closely with a psychiatrist throughout the course of treatment if depressive symptoms are associated with medication, and the benefit of continuing the medication outweighs the risk. In these situations, antidepressant therapy should be considered.

#### Key Point

Patients co-infected with hepatitis C virus (HCV), patients receiving treatment with

interferon, and patients with disfiguring side effects of antiretroviral (ARV) therapy, particularly body fat changes, are more prone to develop depressive symptoms.

*Depression in Patients with Human Immunodeficiency Virus (HIV)/Hepatitis C Co-Infection*

Clinicians who prescribe interferon-alpha should screen patients for depression at least every 4 weeks while they are receiving treatment (Hauser et al., 2002).

Clinicians who prescribe interferon-alpha should consult with a psychiatrist when treating patients with a history of psychiatric disorders, including depression and substance use.

Key Point

There is a growing amount of evidence that a history of psychiatric disorders, such as depression, does not necessarily increase the risk of developing depression while receiving interferon.

*Depression in Patients Experiencing Body Fat Changes*

Clinicians should assess mood at every visit in patients who develop changes in body fat.

Key Point

Patients report that clinicians minimize the importance of body fat changes.

**Management of HIV-Infected Patients with Depression**

Clinicians should implement interventions, such as medications or psychotherapy, for patients with moderate to severe depression or mild depression that does not resolve in 2 to 4 weeks.

*Referral*

Patients at high risk for suicide or other violent behavior should be referred for immediate psychiatric intervention.

*Antidepressant Medications*

Clinicians should individualize therapy, considering drug-drug interactions with HIV-related medications, presence of comorbid psychiatric disorder(s), presenting symptoms, and side effect profile.

Key Point

As in other vulnerable populations, the concept "start low, go slow" remains the cornerstone of psychiatric medication prescribing for HIV-infected patients.

Refer to Table 3 in the original guideline document for a list of commonly used antidepressants.

Refer to [Appendix II: Interactions Between HIV-Related Medications and Psychotropic Medications](#) in the "Availability of Companion Documents" field for dosing information, side effect profile, and drug-drug interactions.

#### Selective Serotonin Reuptake Inhibitors (SSRI) and Novel Antidepressant Medications

Clinicians should ask patients who are receiving SSRIs about sexual side effects.

Clinicians should monitor patients for suicidal ideation during the initiation phase of SSRI treatment. Clinicians should consider discontinuing medication in patients whose depression is persistently worse or whose emergent suicidality is severe, abrupt in onset, or was not part of the presenting symptoms.

#### Tricyclic Antidepressants

Clinicians should monitor serum drug levels to ensure appropriate dosing of tricyclic antidepressants when there are concerns about adherence, absorption, or drug interactions.

#### *Psychotherapy*

Clinicians should refer patients for psychotherapy in the following situations:

- When basic supportive psychoeducational interventions are deemed ineffective in alleviating mood symptoms
- When patients with depressive symptoms refuse (or prefer not to take) recommended psychotropic medication
- When situational events precipitate mild to moderate depressive symptoms
- When patients appear to have difficulty accepting the diagnosis of a mood disorder (especially when this appears to cause high-risk behavior or non-adherence to medication)
- When patients request a referral

#### Key Point

Combining psychotherapy with antidepressant and mood-stabilizing medications is the most effective treatment option for many patients. If treatment with medications is not possible (e.g., some patients in recovery are opposed to taking psychotropic medications), psychotherapy alone may be as effective as medication in cases of mild to moderate depression.

#### *Alternative Therapies for Depression*

Clinicians should inform patients who decide to use alternative treatments of the following:

- Drug interactions and toxicities may occur.

- These treatments may take longer to be effective.
- These medications are not well studied.

Clinicians should inform patients that concomitant use of St. John's Wort with protease inhibitors (PIs) or non-nucleoside reverse transcriptase inhibitors (NNRTIs) is contraindicated because it may lead to subtherapeutic antiretroviral (ARV) drug concentrations.

### *Treatment Follow-Up*

After initiating treatment, clinicians should schedule a brief visit or phone conversation every 1 to 2 weeks to support adherence, assess response and side effects, and remind the patient that it may take 3 weeks or longer for mood to improve. After 3 to 4 weeks, the clinician should perform an in-person assessment of symptom improvement.

During the maintenance phase of treatment with antidepressant medication, clinicians should schedule a brief visit every 4 to 12 weeks to assess adherence, sustained therapeutic response, and side effects.

After referring patients to another provider for medication or psychotherapy, primary care clinicians should schedule a brief visit or phone conversation within 1 to 4 weeks after the referral to ensure that the patient followed through (Simon et al., 2004).

Clinicians should encourage patients who experience recurrent depression to remain on medication indefinitely.

Primary care clinicians should maintain ongoing coordination of care with the patient's mental health care provider.

### **Treatment of Depression in Pregnant Women**

Clinicians should screen all HIV-infected pregnant women for depression at least once each trimester, including the first prenatal visit, and should educate patients about the risks of perinatal depression.

When treatment is indicated, clinicians and HIV-infected pregnant women should discuss the risks and benefits of antidepressant therapy. The discussion should include the following:

- Patient's history of depression
- Patient's past response to medication
- Increased risk for postpartum depression
- Risks of prenatal exposure to psychotropic medication versus the benefit of stabilizing the patient's depressive symptoms
- Possible drug-drug interactions between antidepressants and ARV medications

Clinicians should evaluate pregnant patients for the use of antidepressant medication, alone or in combination with nonpharmacologic treatment, when

patients present with moderate to severe depression, a history of postpartum depression, or recurrent major depression.

Primary care clinicians should refer HIV-infected pregnant women with depression to a psychiatrist when treatment considerations are complicated by:

- The presence of a co-occurring mental health disorder or when the patient's depression is a feature of an underlying mental health disorder
- Previous non-response to antidepressive therapy
- Possible drug-drug interactions with other medications
- Allergic reactions to antidepressant medications

Refer to Table 4 in the original guideline document for considerations for psychotropic medications during pregnancy.

### *Screening and Treatment of Postpartum Depression*

Primary care clinicians or obstetrical care providers should screen for postpartum depression in HIV-infected women at the routine 4- to 6-week postpartum obstetrical visit; a depression screen should also be performed at 2 to 3 weeks postpartum in women with a current or previous diagnosis of depression.

All clinicians involved in the care of the mother and newborn (e.g., the obstetrician, the HIV primary care clinician, the pediatrician) should be vigilant for signs and symptoms of postpartum depression. If the mother is identified as having postpartum depression, the identifying clinician should inform all other providers of the mother's depression after obtaining her consent.

#### Key Point:

Because pediatricians see the mother and infant more often in the first few weeks postpartum, they are in a unique position to detect depressive symptoms in mothers, including difficulty forming a maternal bond with the infant.

### **Mania**

Clinicians should immediately refer patients experiencing mania for psychiatric evaluation and care.

### **Diagnosis**

Clinicians should consult with or refer patients to a psychiatrist when there is doubt concerning the diagnosis.

Clinicians should consult with or refer patients to a psychiatrist when it is not clear whether patients are hypomanic or depressed.

Clinicians should use the *DSM-IV* diagnostic criteria for mania (see table below).

<b>Table: Diagnostic Criteria for Manic Episode</b>
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**Table: Diagnostic Criteria for Manic Episode**

- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).**
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:**
  - 1. Inflated self-esteem or grandiosity
  - 2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
  - 3. More talkative than usual or pressure to keep talking
  - 4. Insomnia or hypersomnia nearly every day
  - 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
  - 6. Flight of ideas or subjective experience that thoughts are racing
  - 7. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
  - 8. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
  - 9. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- C. The symptoms do not meet criteria for a Mixed Episode.**
- D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.**
- E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).**

**Diagnostic Criteria for Mixed Episode**

- A. The criteria are met both for a Manic Episode and for a Major Depressive Episode (except for duration) nearly every day during at least a 1-week period.**
- B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.**
- C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).**

**Diagnostic Criteria for Hypomanic Episode**

- A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.**
- B. During the period of mood disturbance, three (or more) of the**

Table: Diagnostic Criteria for Manic Episode
<p><b>following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:</b></p> <ol style="list-style-type: none"> <li>1. Inflated self-esteem or grandiosity</li> <li>2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)</li> <li>3. More talkative than usual or pressure to keep talking</li> <li>4. Flight of ideas or subjective experience that thoughts are racing</li> <li>5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)</li> <li>6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation</li> <li>7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)</li> </ol> <p><b>C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.</b></p> <p><b>D. The disturbance in mood and the change in functioning are observable by others.</b></p> <p><b>E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.</b></p> <p><b>F. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).</b></p> <p><b>Note:</b> Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder.</p>

## Management of HIV-Infected Patients with Mania

Until patients with mania are stabilized, clinicians should maintain consultation with a psychiatrist or the patient should be under psychiatric care.

### *Medications*

<p><u>Key Point</u></p> <p>Treating hypomanic patients with antidepressants may lead to a full-blown episode of mania.</p>
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Refer to Table 6 in the original guideline document for commonly used medications to treat mania.

## CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

- Appropriate screening, diagnosis, and treatment of depression and mania in patients with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Simple screening techniques tested in a general primary care setting have been shown to be effective in detecting unrecognized depression.
- Mild depression may resolve within 2 to 4 weeks with support and education alone. For some patients, medication alone may be sufficient to ease their depression; for others, the combination of medication and psychotherapy will provide a more effective and perhaps faster response.

### POTENTIAL HARMS

Refer to [Appendix II](#): interactions between HIV-related medications and psychotropic medications in the "Availability of Companion Documents" field for side effect profile and drug-drug interactions.

## CONTRAINDICATIONS

### CONTRAINDICATIONS

Concomitant use of St. John's Wort with protease inhibitors (PIs) or non-nucleoside reverse transcriptase inhibitors (NNRTIs) is contraindicated because it may lead to subtherapeutic antiretroviral (ARV) drug concentrations.

Refer to [Appendix II](#): interactions between HIV-related medications and psychotropic medications in the "Availability of Companion Documents" field for contraindications between human immunodeficiency virus (HIV)-related medications and psychotropic medications.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

The AIDS Institute's Office of the Medical Director directly oversees the development, publication, dissemination and implementation of clinical practice guidelines, in collaboration with The Johns Hopkins University, Division of Infectious Diseases. These guidelines address the medical management of adults, adolescents and children with human immunodeficiency virus (HIV) infection; primary and secondary prevention in medical settings; and include informational brochures for care providers and the public.

### **Guidelines Dissemination**

Guidelines are disseminated to clinicians, support service providers and consumers through mass mailings and numerous AIDS Institute-sponsored educational programs. Distribution methods include the HIV Clinical Resource website, the Clinical Education Initiative (CEI), the AIDS Educational Training Centers (AETC) and the HIV/AIDS Materials Initiative. Printed copies of clinical guidelines are available for order from the New York State Department of Health (NYSDOH) Distribution Center for providers who lack internet access.

### **Guidelines Implementation**

The HIV Clinical Guidelines Program works with other programs in the AIDS Institute to promote adoption of guidelines. Clinicians, for example, are targeted through the CEI and the AETC. The CEI provides tailored educational programming on site for health care providers on important topics in HIV care, including those addressed by the HIV Clinical Guidelines Program. The AETC provides conferences, grand rounds and other programs that cover topics contained in AIDS Institute guidelines.

Support service providers are targeted through the HIV Education and Training initiative which provides training on important HIV topics to non-physician health and human services providers. Education is carried out across the State as well as through video conferencing and audio conferencing.

The HIV Clinical Guidelines Program also works in a coordinated manner with the HIV Quality of Care Program to promote implementation of HIV guidelines in New York State. By developing quality indicators based on the guidelines, the AIDS Institute has created a mechanism for measurement of performance that allows providers and consumers to know to what extent specific guidelines have been implemented.

Finally, best practices booklets are developed through the HIV Clinical Guidelines Program. These contain practical solutions to common problems related to access, delivery or coordination of care, in an effort to ensure that HIV guidelines are implemented and that patients receive the highest level of HIV care possible.

## **IMPLEMENTATION TOOLS**

Personal Digital Assistant (PDA) Downloads  
Pocket Guide/Reference Cards

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better  
Living with Illness

### IOM DOMAIN

Effectiveness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Depression and mania in patients with HIV/AIDS. New York (NY): New York State Department of Health; 2008 Jun. 23 p. [27 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

2005 Feb (revised 2008 Jun)

### GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

### SOURCE(S) OF FUNDING

New York State Department of Health

### GUIDELINE COMMITTEE

Mental Health Guidelines Committee

### COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

*Chair:* Milton L Wainberg, MD, New York State Psychiatric Institute, New York, New York

*Committee Members:* Bruce D Agins, MD, MPH, New York State Department of Health AIDS Institute, New York, New York; Kalyana Battu, MD, Albany Medical Center, Albany, New York; Barbara A Conanan, RN, MS, Saint Vincent's Manhattan Department of Community Medicine, New York, New York; Joseph Z Lux, MD,

Bellevue Hospital, New York, New York; Peter Meacher, MD, AAHIVS, FAAFP, South Bronx Health Center for Children and Families, Bronx, New York; Yiu Kee Warren Ng, MD, New York Presbyterian Hospital, Columbia University Medical Center, New York, New York; Bella M Schanzer, MD, MPH, Columbia University Medical Center, New York, New York

*Liaisons:* Francine Cournos, MD, Liaison to the New York/New Jersey AIDS Education and Training Center, Columbia University, New York State Psychiatric Institute, New York, New York; James J Satriano, PhD, Liaison to the New York State Office of Mental Health, Columbia University College of Physicians and Surgeons, New York, New York

*AIDS Institute Staff Liaison:* L Jeannine Bookhardt-Murray, MD, Harlem United Community AIDS Center, New York, New York

*AIDS Institute Representative:* Heather A Duell, LMSW, New York State Department of Health AIDS Institute, Bureau of Community and Support Services, Albany, New York

*Principal Contributors:* Francine Rainone, PhD, DO, MS, Montefiore Medical Center, Bronx; L Jeannine Bookhardt-Murray, MD, Harlem United Community AIDS Center, New York; Milton L Wainberg, MD, Columbia University, New York; Gina M Brown, MD, New York City Department of Health and Mental Hygiene, New York

## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Not stated

## **GUIDELINE STATUS**

This is the current release of the guideline.

This guideline updates a previous version: Depression and mania in patients with HIV/AIDS (updated online 2005 Mar). In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2001 Mar. p. 1-20.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following are available:

- Mental health quick reference card. New York (NY): New York State Department of Health; 2006 Jan. 2 p. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

- Appendix I: mental health screening tools. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix II: interactions between HIV-related medications and psychotropic medications: New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

This guideline is available as a Personal Digital Assistant (PDA) download from the [New York State Department of Health AIDS Institute Web site](#).

## **PATIENT RESOURCES**

None available

## **NGC STATUS**

This NGC summary was completed by ECRI on May 5, 2005. This summary was updated by ECRI Institute on November 9, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs. This guideline was updated by ECRI Institute on September 2, 2008.

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